

SUCTION MACHINE & SUPPLIES STANDARD WRITTEN ORDER

 <p align="center">Please fax to: Anchorage (907) 274-0773 Fairbanks (907) 458-8914 Soldotna (907) 260-3757 Wasilla (907) 357-7883 or email to: dme@procarehm.com</p>	Patient Name, Address, Telephone & Insurance ID #: Phone: _____ Ins ID# : _____
	Patient DOB: _____ Sex: _____ (M/F)

Refer to the suction machine coverage criteria sheet for all required documentation.

SUCTION MACHINE AND SUPPLIES:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=life) Patient Height: _____ in. Weight: _____ lbs.

Equipment:

Suction Machine (E0600) with canister (2/month) and suction tubing (2/month)

Type of Suction:

Oral (Yankauer Tip) 12/mo Tracheal (Suction Catheter) 90/mo Size: _____

Other: _____ Qty: _____

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____